What the coronavirus pandemic means for U.S. health insurance

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The United States has confirmed more cases of the novel coronavirus than any other country in the world, with infections topping 370,000. The rapid increase in patients is straining hospitals across the

nation—and poses pressing questions for its health insurance programs.

For Prof. Katherine Baicker, a leading health economics researcher at the University of Chicago, the current crisis has highlighted two important recommendations: Changing the way that we pay for care to maximize health and promote medical innovation, and making a more robust safety net that everyone can access.

But structural changes are difficult to enact and implement in the midst of a public health crisis. The dean of the Harris School of Public Policy, Baicker said that to help those in need right now, state and local governments can take immediate steps to lift barriers to care—steps that can, in turn, help identify and tamp down COVID-19 outbreaks.

The following conversation has been edited and condensed.

Does the coronavirus fundamentally shift how we should view health care?

Usually when we think about cost sharing in insurance programs, the effects on health care use that affect the enrollee's own health are much bigger than concerns about the spillover effects of that care to other people's health. But the coronavirus amplifies those spillover effects.

In an era of pandemics, everyone's access to health care very much affects everyone else. Someone getting sick increases the possibility of other people getting sick—and one's use of health care resources may reduce the resources available for other people. There are multiple ways that our individual health is tied to the nation's health.

That element is always there. We're in an active pandemic now—but even if we are not in that state of the world, there is always the

possibility of a pandemic. Our public health insurance programs ought to be designed for that reality. Probably even more importantly, our health care infrastructure has to be designed for that reality.

How does this change how public health insurance is designed?

Insurance programs ought to be designed in ways that incorporate the effects of health care on an individual's health and the health of other people in their community, and that design co-pays to steer resources towards the care of greatest health benefit. There ought to be no co-pays for COVID-19 testing and care. There also ought to be lower co-pays for lots of other care that has important health benefits for individuals, but higher co-pays for care that has limited health benefit. The principles are actually consistent: We need to make sure that our insurance design incorporates both individual and community health effects of access to care.

What's one change that can help COVID-19 patients in the short term?

We could loosen restrictions on sites of care to make telemedicine more broadly available in situations where it might not otherwise be reimbursed. That's really important, both for expanding capacity and for limiting in-person contact—particularly for vulnerable populations.

Low-risk patients may be more likely to be able to care for themselves at home. But a trip to see a health care provider may be more dangerous for a high-risk person. When you think about that first consultation, you want to minimize the need for high-risk populations to go into high-risk sites of care. Having the option to conduct that first visit remotely is important.

Alternative, broadly accessible modes of care also enable better monitoring and surveillance of individual and population health. Because we don't have robust population health monitoring and testing in place, looking for people with the constellation of symptoms consistent with COVID-19 is an important tool to monitor the spread of the disease.

Does COVID-19 change the conversation about whether or not insurance should primarily be tied to employment?

It certainly brings the issue into crucial focus—particularly the hardship faced by those who are not only losing their jobs, but losing their health insurance. This is something that was an area of active debate before the pandemic, with the public discourse on Medicare for All, versus exchanges, versus employer health insurance. But I do not imagine that, as a country, we're in a position to do a major overhaul of our health care system right now—rather than rapid expansion of multiple avenues in our system to get people care.

Right now, the focus has to be on measures to mitigate the spread of the disease. And to expand our capacity to treat it—personnel, hospital beds, social distancing, reducing disease transmission. That has to be our short-term, and probably medium-term, focus. Fixing health insurance markets is just going to take longer than we have in the midst of a crisis. But moving forward, the crisis will surely influence the public debate about the mechanisms through which we all get our health insurance and health care.

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